

I thank my colleagues for their insightful comments and for starting the debate on new professionalism. Long may it continue.

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3. Rothman DJ. Medical professionalism — focusing in on the real issues. *N Engl J Med* 2000; 342: 1284-1286.
4. Irvine D. Doctors in the UK: their new professionalism and its regulatory framework. *Lancet* 2001; 358: 1807-1810. □

Developing a core clinical data set for cancer

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TO THE EDITOR: Optimising the management of cancer patients requires objective decisions about “best treatment” strategies, based on high quality data collected systematically from all treated patients (or at least a representative sample of them). Relating treatment and stage at diagnosis to individual outcome can allow monitoring of whether treatment is consistent with best practice, and can provide a systematic foundation for evidence-based care. Clinical cancer data collection also allows treatment services to be evaluated, as institutions can monitor throughput and endpoints. However, institution-based data collections may not be representative of all cancer patients, and aggregation of data from several institutions is needed to obtain a comprehensive picture.

Population-based cancer registries, which operate in all Australian States and Territories, include data on the site and morphology of cancers. Notification of cases to the registries is mandatory for hospitals and pathology providers, and survival of patients is assessed by linkage to mortality data. The registers do not routinely record stage or treatment data. Until recently, there have been no nationally agreed data items or standard data definitions to facilitate the collation of clinical cancer data across institutions.

In 1999, the National Cancer Control Initiative (NCCI) commissioned a nationwide consultation process to seek expert advice on developing a core clinical cancer data set. Representatives from the State and Territory population-based cancer registries, the Australian Institute of Health and Welfare and many large cancer treatment

centres were consulted.¹ A workshop was held in Melbourne in July 2000 to identify key items for inclusion in the data set, and a group was established to work on data definitions. These are now available on the NCCI's website (<<http://www.ncci.org.au/projects/data/dat01.htm>>). The data set is designed to be compatible with, and expand on, data currently collected by State cancer registries. Definitions are consistent with the New South Wales clinical cancer data set,² and we acknowledge the input from this source. Items would be collected by treatment centres. Some institutions would need to standardise information already collected for ongoing patient management, while others would need to establish and maintain new collections. The Faculty of Radiation Oncology of the Royal Australian and New Zealand College of Radiologists has recommended incorporation of the NCCI data set into its proposed quality assurance program. Collation of data across institutions requires careful attention to patient identification issues in order to protect privacy and avoid duplication of data from multiple sources.

Use of the data set by clinicians and health planners and evaluators at a national level is the ultimate aim. This would require funding and commitment, and attention to issues of privacy, confidentiality, and data ownership. At present, adoption of the data set on a voluntary basis by treatment centres is the best way forward.

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2. NSW clinical cancer data collection for outcomes and quality. Data dictionary. Version 1. Sydney: Public Health Division, NSW Health, 2001. □

Does intramuscular botulinum toxin A injection improve upper-limb function in children with hemiplegic cerebral palsy?

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TO THE EDITOR: We applaud the efforts of Wasiak et al to apply the principles of evidence-based medicine to answer clinical questions.¹ However, it is important to understand the historical context of clinical trials reported in the literature, and, when

necessary (eg, when conducting a meta-analysis or when the results of trials appear to conflict), to seek additional information from the authors.

One of us (H K G) designed the randomised-controlled trial (RCT) reported by Corry et al.² It was a pilot study and not a definitive clinical trial. The primary outcome measure was resonant frequency, an objective measure of muscle stiffness. This trial was conducted before the introduction of validated outcome measures for assessing upper limb function in children with cerebral palsy, and it was not possible to perform any sample size calculation for functional outcomes. At 12 weeks in the group receiving injections of botulinum toxin A, there was a significant difference in grasp and release but not in the ability to pick up coins. It is not surprising therefore that this study found significant decreases in muscle stiffness, but the functional results were inconclusive.

The other RCT identified by Wasiak et al also involved one of us (D F).³ It was designed specifically to investigate functional outcomes, a sample size calculation was performed from pilot work, and a specific functional outcome measure (QUEST) was used. This study reported significant functional improvements after the use of botulinum toxin combined with occupational therapy.

These two studies, when understood in their historical sequence, should therefore be considered complementary and not contradictory. It is important to assess the quality of randomised clinical trials as well as their conclusions (eg, using the Physiotherapy Evidence database PEDRO scale <<http://ptwww.fhs.usyd.edu.au/pedro>>).^{4,5} The smaller study by Corry et al² had insufficient power and inadequate methodology to investigate functional outcomes. On the other hand, the conclusions of the study by Fehlings et al³ should be taken as the current level of evidence. We therefore submit that the conclusion drawn by Wasiak et al is incorrect. We support further research to evaluate and strengthen the evidence relating to botulinum toxin A and upper-extremity function.⁶

1. Wasiak J, Hoare BJ, Hender KM. Does intramuscular botulinum toxin A injection improve upper-limb function in children with hemiplegic cerebral palsy? *Med J Aust* 2002; 177: 158.
2. Corry IS, Cosgrove AP, Walsh EG, et al. Botulinum toxin A in the hemiplegic upper limb: a double-blind trial. *Dev Med Child Neurol* 1997; 39: 185-193.
3. Fehlings D, Rang M, Glazier J, Steele C. An evaluation of botulinum toxin A injection to improve upper extremity function in children with hemiplegic cerebral palsy. *J Pediatr* 2000; 137: 331-337.
4. Verhagen AP, de Vet HC, De Bie RA, et al. The Delphi list: a criteria list for quality assessment of randomised clinical trials for conducting systematic reviews. *J Clin Epidemiol* 1998; 51: 1234-1241.